

ATTACHMENT 6

Prior Authorization Request Form (PA/RF)

Completion Instructions for hospital services

(For prior authorization requests submitted after HIPAA implementation)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests with either the Prior Authorization/Substance Abuse Attachment (PA/SAA) or the Prior Authorization/Psychotherapy Attachment (PA/PSYA)* by fax to Wisconsin Medicaid at (608) 221-8616; or, providers submit PA requests with attachments to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type

Enter the appropriate three-digit processing type from the list below. The processing type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

* The PA/AA and PA/PSYA are only used for outpatient hospital services.

Inpatient Hospital

- 117 — Physician Services (includes Family Planning Clinics, Rural Health Clinics, and Federally Qualified Health Centers)
- 133 — Transplant Services
- 134 — Acquired Immune Deficiency Syndrome (AIDS) Services (hospital and nursing home)
- 135 — Ventilator Service
- 999 — Other (use only if the requested category or service is not listed above)

Outpatient Hospital

- 127 — Psychotherapy (UB-92 billing providers only)
- 128 — Substance Abuse Services (other than Day Treatment)
- 999 — Other (use only if the requested category or service is not listed above)

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

Element 6 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient

Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Sex — Recipient

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 14 — Requested Start Date (not required)

Element 15 — Performing Provider Number (not required)

Element 16 — Procedure Code

Enter the appropriate *Current Procedural Terminology* procedure code, National Uniform Billing Committee revenue code, Healthcare Common Procedure Coding System procedure code, or ICD-9-CM surgical code for each service/procedure/item requested.

Element 17 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 18 — POS

Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 19 — Description of Service

Enter a written description corresponding to the appropriate code for each service/procedure/item requested.

Element 20 — QR

Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Inpatient Hospital

Brain injury care services	Number of days
Hospital transplant	Per hospital stay
Hospital and nursing home AIDS services	Number of days
Hospital and nursing home ventilator services	Number of days

Outpatient Hospital

Psychotherapy	Number of sessions
Substance abuse	Number of sessions

Element 21 — Charge

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 24 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.